Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 07/01/2009 NVS5007HIC STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 944 SADDLE HORN DR **CELE'S CARE HOME** HENDERSON, NV 89015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 000 H 000 Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 7/01/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The census at the time of the survey was one. One resident file and three employee files were reviewed. The following deficiencies were identified: Y HOI8 H 018 H 018 Director Duties-BLC&DAS Phone Numbers NAC 449.15523 Director: Duties. (NRS 449.249) A. The phone numbers of for the Bureau of Health Care Quality The director of a home shall: 3. Ensure that the residents of the home: (b) Receive: (4) The names of, and the telephone numbers for the registration of complaints with the bureau and the aging services division of the department of human resources. This Regulation is not met as evidenced by: Based on observation, interview and record review on 7/1/09, the director did not ensure that the names and telephone numbers for registration of complaints with the Bureau of If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Cultura

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07/01/2009

Bureau of Health Care Quality & Compliance

STATEMENT	OF DEFICIENCIES
AND PLAN OF	F CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED

NVS5007HIC

STREET ADDRESS, CITY, STATE, ZIP CODE

944 SADDLE HORN DR

			SON, NV 89015			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
H 018	Continued From page 1 Health Care Quality and Compliance an Division for Aging Services were made at to 1 of 1 residents (Resident #1).	d the	H 018	B. The Caregivers and director will check	, al	
H 050	Tuberculosis-Employees NAC 441A.375 Medical facilities, facilitie dependent and homes for individual rescare: Management of cases and suspectases; surveillance and testing of employees counseling and preventive treatment. 1. A case having tuberculosis or suspectations of the considered to have tuberculosis in a medicality or a facility for the dependent multiple managed in accordance with the guidelicenters for Disease Control and Preventions.	es for the idential cted cyees; cted case edical ast be ines of the	н 050	everyday that the li is always available for the residents. The director will monitor for com- pliance. C. 7/15/09		
	adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the depart home for individual residential care shappened a home for tuberculosis and tuberculosis infection. The surveillance of employees conducted in accordance with the recommendations of the Centers for Discontrol and Prevention for preventing the transmission of tuberculosis in facilities health care set forth in the guidelines of Centers for Disease Control and Prevention 1 of NAC 441A.200. 3. Before initial employment, a person of in a medical facility, a facility for the depart home for individual residential care shaped a home for individual residential care shaped a home for the seamination or certification.	pendent or nall he facility sis s must be sease ne providing f the ntion as of employed pendent or nall have		A. Employee # 1 and #3 have been sche- duled to see their doctor for physical efam and for TB tests on July 20, 200 Imployee # 2 has seen her doctor for physical exam and	0K 9.	
	licensed physician that the person is in good health, is free from active tubercu any other communicable disease in a c stage; and	losis and ontagious		ment # 2.		

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS5007HIC 07/01/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 944 SADDLE HORN DR **CELE'S CARE HOME** HENDERSON, NV 89015 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) H 050 H 050 Continued From page 2 (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and

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Prevention as adopted by reference in paragraph

7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall

(g) of subsection 1 of NAC 441A.200.

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PRINTED: 07/06/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS5007HIC 07/01/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 944 SADDLE HORN DR **CELE'S CARE HOME** HENDERSON, NV 89015 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** DEFICIENCY) H₀₅₀ H 050 Continued From page 3 report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. (Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006) This Regulation is not met as evidenced by: Based on record review on 7/01/09, the facility failed to ensure that 3 of 3 caregivers complied with NAC 441A.375 regarding a physical examination (Employee #1, #2 and #3), 2 of 3 caregivers complied with NAC 441A.375 regarding tuberculosis (TB) testing (Employee #1 and #3), and 1 of 3 caregivers complied with NAC 441A.375 regarding a TB signs and symptoms review (Employee #2).

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